



# Camper Forms Packet

*These forms are valid for all City of Boulder Camp programs.  
Camp programs include the following programs: School Day Off Camps,  
and Summer Camps.*

**CAMPER NAME:** \_\_\_\_\_

Dear Parents/Guardians,

Thank you for participating in a City of Boulder Camp program. This packet contains all of the forms you will need to complete prior to sending your child to camp.

Please note that these are participant information forms, and are not registration forms. In order to register for a City of Boulder Camp program, please visit [www.BPRCamps.org](http://www.BPRCamps.org) or call 303-413-7270 or visit any recreation center in the City of Boulder.

Only one packet of forms is required for the calendar year per camp location. If attending multiple different camps throughout the year you will need to bring new paperwork to each location.

**Please save a copy of these forms if your child is attending camp at different locations.**

Find us online: [www.BPRCamps.org](http://www.BPRCamps.org)

Please note: The included immunization form or your doctor's office print out are acceptable forms for immunization documentation per the Colorado Department of Health and Human Services, Child Care Division.

A complete camper forms packet will include:

- ☐ Camper Emergency Information Card
- ☐ Camper Information Sheet
- ☐ Medical History & Information Form
- ☐ Authorization to Administer Medication (Optional)
- ☐ Camper Permissions
- ☐ Colorado Department of Public Health and Environment-  
Certificate of Immunization



Please print on regular white paper and complete all areas, top and bottom. Return on this full, 8.5 x 11 sheet of paper and staff will cut and laminate the card.

CAMPER EMERGENCY INFORMATION CARD			
CHILD'S LAST NAME	CHILD'S FIRST NAME	BIRTHDATE (MM/DD/YY)	AGE
CHILD'S HOME ADDRESS			GENDER <input type="checkbox"/> M <input type="checkbox"/> F
CITY	ZIP	HOME PHONE	
PARENT/GUARDIAN'S NAME	HOME PHONE	ALT PHONE	
PARENT/GUARDIAN'S NAME	HOME PHONE	ALT PHONE	
AUTH. TO PICK UP/EMERG CONTACT	CONTACT ADDRESS	CONTACT PHONE	
AUTH. TO PICK UP/EMERG CONTACT	CONTACT ADDRESS	CONTACT PHONE	
AUTH. TO PICK UP/EMERG CONTACT	CONTACT ADDRESS	CONTACT PHONE	
HEALTH CONCERNS, ALLERGIES, BEHAVIORAL CONCERNS, ETC.			(OVER)

FOLD HERE



# Camper Information Sheet

**Today's Date**

MM/DD/YY

/ /

## Camper Information

Child's Full Name \_\_\_\_\_ Nickname \_\_\_\_\_

Child's Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Gender M F Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

## Parent/Guardian Information

Parent/Guardian Name \_\_\_\_\_ Preferred Phone # ( ) \_\_\_\_\_

Home Address if Different \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Additional Phone # ( ) \_\_\_\_\_ Additional Phone # ( ) \_\_\_\_\_ Email \_\_\_\_\_

Employment Address \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Preferred Phone # ( ) \_\_\_\_\_

Home Address if Different \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Additional Phone # ( ) \_\_\_\_\_ Additional Phone # ( ) \_\_\_\_\_ Email \_\_\_\_\_

Employment Address \_\_\_\_\_

## Authorization to Pick Up/Drop Off and Emergency Contacts

**Please list up to four individuals as people authorized to pick up/drop off your child from camp. In addition to the parents/guardians, these individuals will also be used as emergency contacts. Requests for additional contacts can be made in writing to Camp Director.**

Name \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Address \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Address \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Address \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Address \_\_\_\_\_ Relationship \_\_\_\_\_



# Medical History & Information Form

Today's Date

MM/DD/YY

/ /

Child's Name \_\_\_\_\_

Please check all illnesses that your child HAS had

Chicken Pox

Measles

Rubella

Hay Fever

Rheumatic Fever

Asthma

Epilepsy

Mumps

Poliomyelitis

Whooping Cough

Diabetes

Please fill out information below

Surgery/Accidents/Illnesses/Chronic Health Problems \_\_\_\_\_

Describe any physical or medical condition requiring special attention by staff \_\_\_\_\_

Check those allergies staff should be aware of and give the prescribed routine below

Food (type) \_\_\_\_\_ Insect Bites/Stings \_\_\_\_\_

Medications \_\_\_\_\_ Other \_\_\_\_\_

Date of most recent medical examination of this child \_\_\_\_/\_\_\_\_/\_\_\_\_

**PLEASE RECORD IMMUNIZATIONS AND DATE ADMINISTERED ON THE COLORADO DEPARTMENT OF HEALTH CERTIFICATE OF IMMUNIZATION FORM OR KAISER PERMANENTE APPROVED FORM**

Physician/Health Care Professional \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Office Address \_\_\_\_\_

Medical Insurance Company \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Group # \_\_\_\_\_

Dentist Name \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Office Address \_\_\_\_\_

Hospital of Choice \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Any intolerance to drugs, medication, sunscreen or food? \_\_\_\_\_

This medical history and information is correct as far as I know and the person herein described has permission to engage in all prescribed activities, unless otherwise stated.

Parent/Guardian Initial \_\_\_\_\_



OPTIONAL:  
AUTHORIZATION TO  
ADMINISTER MEDICATION

Today's Date  
MM/DD/YY  
/ /  
\_\_\_\_\_

For children who need to take over the counter or prescription medications during City of Boulder Camp programs, this form needs to be completed in its entirety by a parent/guardian and physician before any medication can be given by staff. If the form is incomplete or not on file, the parent/guardian will be asked to return to City of Boulder Camp Program to administer the medication regardless of the age of the child.

Parent/Guardian, please complete this section

The parent/guardian of \_\_\_\_\_ ask that staff give the following medication  
(child's first and last name)  
\_\_\_\_\_ at \_\_\_\_\_ to my child, according  
(Name of Medication, one medication per sheet) (Time)

to the Health Care Provider's signed instructions on the lower part of this form.

**Prescription Medications** must come in the original container labeled with: child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped, and a licensed health care provider's name. Pharmacy name and phone number must also be included on the label. Ask your pharmacist for a separate medicine bottle to keep at camp.

**Over the counter medication** must be labeled with the child's name. Dosage must match the signed health care provider authorization, and medicine must be packed in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the staff

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Parent/Guardian's Printed Name Parent/Guardian's Signature Date  
( ) ( ) ( )  
\_\_\_\_\_  
Home Phone Work Phone Cell Phone

Health Care Provider Authorization to administer medication at City of Boulder Camp programs.

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Medication \_\_\_\_\_ Dosage \_\_\_\_\_  
Route \_\_\_\_\_  
Special Instructions \_\_\_\_\_  
Purpose of medication \_\_\_\_\_  
Side effect that need to be reported \_\_\_\_\_  
\_\_\_\_\_  
Physician/Health Care Professional Signature Date \_\_\_\_/\_\_\_\_/\_\_\_\_\_



**Today's Date**

MM/DD/YY

/ /

## Camper Permissions

### Emergency Medical Service Release

I hereby give my permission to the City of Boulder staff to call a doctor or emergency medical service and for the doctor, hospital or medical service to provide emergency medical or surgical care for my child should an emergency arise. It is understood that the City of Boulder staff will make a conscientious effort to locate the parent/guardian or the emergency contact listed on the registration document, however the priority will be the child's emergency. If it is not possible to locate the emergency contact listed, I will accept the expense of emergency medical or surgical treatment.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

### Sunscreen Permission

Children will apply sunscreen to themselves under the direct supervision of camp staff, 15-30 minutes before outdoor activities. As a backup option, The City of Boulder Camps will have Rocky Mountain Spray Sunscreen Kids SPF 50+. Camp staff can help spray sunscreen on children, but the child will be responsible for rubbing the sunscreen in. Sunscreen will NOT be applied to any broken skin or if a skin reaction has been observed. Any skin reaction observed by camp staff will be reported promptly to a parent/guardian. It is highly encouraged that parents provide sunscreen with 30+ SPF. Please have your child's first and last name clearly labeled on the bottle.

Child's Name:

Name of Sunscreen and SPF # (if providing your own)

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date



# Camper Permissions (Optional)

Today's Date

MM/DD/YY

/ /

## Transportation/Field Trip Authorization

I hereby give permission for my child to go on field trips away from the designated Camp location through the City of Boulder Camp program whether on foot, school bus, bicycle or by City of Boulder vehicles.

I give permission for my child to participate in all City of Boulder Camp activities with the following exceptions: \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Parent/Guardian Date

## Summer Camp Parent Manual - Release Statement of Understanding

By signing below, I understand that it is my responsibility to read the guidelines set forth by the City of Boulder parks and Recreation department and uphold them to the fullest. The Summer Camp Parent Manual is also available online at [www. BPRCamps.org](http://www.BPRCamps.org).

\_\_\_\_\_  
Print Parent/Guardian Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Parent/Guardian Date

## OPTIONAL: Bike/Walk to and/or from City of Boulder Camp Permission

**Must be 10 years of age or older.**

My child \_\_\_\_\_ is 10 years of age or older and has my permission to bike or walk to/from City of Boulder Camps and be released on his/her own. He/she will be responsible for signing him/her self into and/or out of camp each day. I agree that the City of Boulder and the employees will not be responsible for the welfare of my child before camp and once released to go home.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Parent/Guardian Date

**COLORADO LAW REQUIRES THAT THIS FORM BE COMPLETED FOR EACH PARTICIPANT ATTENDING COLORADO CAMPS**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

**COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT—CERTIFICATE OF IMMUNIZATION**

Vaccine		Enter the month, day and year each immunization was given					
<b>Hep B</b>	Hepatitis B						
<b>DTaP</b>	Diphtheria, Tetanus, Pertussis (pediatric)						
<b>DT</b>	Diphtheria, Tetanus (pediatric)						
<b>Tdap</b>	Tetanus, Diphtheria, Pertussis						
<b>Td</b>	Tetanus, Diphtheria						
<b>Hib</b>	<i>Haemophilus influenzae</i> type b						
<b>IPV/OPV</b>	Polio						
<b>PCV</b>	Pneumococcal Conjugate						
<b>MMR</b>	Measles, Mumps, Rubella						
<b>Varicella</b>	Chickenpox						
Vaccines recorded below this line are recommended. Recording of dates is encouraged.							
<b>HPV</b>	Human Papillomavirus						
<b>Rota</b>	Rotavirus						
<b>MCV4/MPSV4</b>	Meningococcal						
<b>Hep A</b>	Hepatitis A						
<b>TIV/LAIV</b>	Influenza						
<b>Other</b>							

**D A) Child Care Up to Date**

Up to date through 6 months of age for Colorado School Immunization Requirements

Update Signature \_\_\_\_\_

Date \_\_\_\_\_

**D B) Child Care Up to Date**

Up to date through 18 months of age for Colorado School Immunization Requirements

Update Signature \_\_\_\_\_

Date \_\_\_\_\_

**D C) Child Care/Pre-school/Pre-K\***

Up to date for Child Care/Pre-School/Pre-K for Colorado School Immunization Requirements

Update Signature \_\_\_\_\_

Date \_\_\_\_\_

**D D) Complete for K–5th Grade**

Up to date for K–5th Grade for Colorado School Immunization Requirements

Update Signature \_\_\_\_\_

Date \_\_\_\_\_

\* If age 4 years and fulfills Requirements for Pre-School & Kindergarten, check BOTH Boxes C and D.

**HAS MET ALL IMMUNIZATION REQUIREMENTS FOR COLORADO SCHOOLS (6TH GRADE OR HIGHER)**

Signed \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_  
(Physician, nurse, or school health authority)

**STATEMENT OF EXEMPTION TO IMMUNIZATION LAW (DECLARACIÓN RESPECTO A LAS EXENCIONES DE LA LEY DE VACUNACIÓN)**

**IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS MAY BE SUBJECT TO EXCLUSION FROM SCHOOL AND TO QUARANTINE.**

**SI SE PRESENTA UN BROTE DE LA ENFERMEDAD, ES POSIBLE QUE A LAS PERSONAS EXENTAS SE LES PONGA EN CUARENTENA O SE LES EXCLUYA DE LA ESCUELA.**

**MEDICAL EXEMPTION:** The physical condition of the above named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.

**EXENCION POR RAZONES MÉDICAS:** El estado de salud de la persona arriba citada es tal que la vacunación significa un riesgo para su salud o incluso su vida; o bien, las vacunas están contraindicadas debido a otros problemas de salud.

*Medical exemption to the following vaccine(s):*

*La exención por razones médicas aplica a la(s) siguiente(s) vacuna(s):*

Signed (Firma) \_\_\_\_\_ Date (Fecha) \_\_\_\_\_  
Physician (Médico)

D D D D D D D D  
Hep B DTaP Tdap Hib IPV PCV MMR VAR

**RELIGIOUS EXEMPTION:** Parent or guardian of the above named person or the person himself/herself is an adherent to a religious belief opposed to immunizations.

**EXENCION POR MOTIVOS RELIGIOSOS:** El padre o tutor de la persona arriba citada, o la persona misma, pertenece a una religión que se opone a la inmunización.

*Religious exemption to the following vaccine(s):*

*Exención por motivos religiosos de la(s) siguiente(s) vacuna(s):*

Signed (Firma) \_\_\_\_\_ Date (Fecha) \_\_\_\_\_  
Parent, guardian, emancipated student/consenting minor  
(Padre, tutor, estudiante emancipado o consentimiento del menor)

D D D D D D D D  
Hep B DTaP Tdap Hib IPV PCV MMR VAR

**PERSONAL EXEMPTION:** Parent or guardian of the above named person or the person himself/herself is an adherent to a personal belief opposed to immunizations.

**EXENCION POR CREENCIAS PERSONALES:** Las creencias personales del padre o tutor de la persona arriba citada, o la persona misma, se oponen a la inmunización.

*Personal exemption to the following vaccine(s):*

*Exención por creencias personales de la(s) siguiente(s) vacuna(s):*

Signed (Firma) \_\_\_\_\_ Date (Fecha) \_\_\_\_\_  
Parent, guardian, emancipated student/consenting minor  
(Padre, tutor, estudiante emancipado o consentimiento del menor)

D D D D D D D D  
Hep B DTaP Tdap Hib IPV PCV MMR VAR



